Prudential

Authorization to Disclose Information to General Agent or Broker

The Prudential Insurance Company of America
Pruco Life Insurance Company
Pruco Life Insurance Company of New Jersey,
all are Prudential Financial companies
Corporate Offices, Newark, New Jersey 07102 – 973-802-6000

I, _____,
(Print name of proposed Insured)

hereby authorize Prudential Insurance Company of America, Pruco Life Insurance Company and/or Pruco Life Insurance Company of New Jersey, their employees, officers, affiliates, (collectively, "Prudential") to release any and all medical and driving information ("Information"), which has been collected by Prudential in connection with my current request for life insurance to the General Agent and Broker submitting that life insurance request. Information includes but is not limited to the results of any motor vehicle records, physical examination or tests, electrocardiogram, chest X-ray and Attending Physician Statements.

It is my understanding that the purpose of this authorization is to facilitate submission of this Information by the General Agent or Broker or their authorized representatives to other insurers to evaluate an application for insurance on my life. I understand that Prudential assumes no liability with respect to any application for insurance to other companies and makes no representation as to the completeness or accuracy of the Information. I also understand that Prudential will only provide disclosures as permitted by law, and, in its sole discretion, may not provide all Information in its possession. It is my responsibility to disclose any and all requested medical information to any insurance carrier to which I apply for insurance coverage.

I further understand that Prudential's privacy policy does not extend to the copy of the Information provided to the General Agent and/or Broker.

This authorization is effective as of the date it is signed and shall continue for six (6) months unless otherwise provided by law. I also understand that I may revoke this authorization by providing written notification to Prudential at Prudential Brokerage, PO Box 7426, Philadelphia, Pennsylvania 19176, which revocation shall be subject to the rights of Prudential to the extent Prudential has acted in reliance on the authorization prior to notice of revocation.

A copy of this authorization shall be as valid as the original.

I acknowledge that I have received a copy of this authorization from the General Agent or Broker.

_____ _____
Signature of Proposed Insured Date

Prudential

CUSTOMER INFORMATION FORM FOR LIFE INSURANCE

☐ **The Prudential Insurance Company of America**
☐ **Pruco Life Insurance Company of New Jersey**
Both are Prudential companies

POLICY NUMBER (IF KNOWN):_____

INSTRUCTIONS

TERM PRODUCTS: Complete sections A-C and sections K-L.

NON-TERM, NON-VARIABLE PRODUCTS: Complete sections A-I and sections K-L.

VARIABLE PRODUCTS: Complete ALL sections.

A. POLICYOWNER'S AND PRIMARY PROPOSED INSURED'S NAME INFORMATION – Complete for all product types.

1. Name of policyowner:_____
2. Name of primary insured:_____

B. POLICYOWNER'S FINANCIAL OBJECTIVE – Complete for all product types.

Select up to two objectives. Indicate policyowner's primary financial objective below by checking the appropriate box in the Primary Financial Objective column. Generally, the financial objective for term insurance is protection/income replacement; however, for permanent coverage, other financial objectives could apply.

Primary Financial Objective (Required- select only one.)
- ☐ Protection/Income Replacement
- ☐ Income
- ☐ Growth
- ☐ Diversified

Secondary Financial Objective (Optional- select only one.)
- ☐ Protection/Income Replacement
- ☐ Income
- ☐ Growth

1. **Protection/Income Replacement** – Seeks to preserve the value of the financial objective, including protection for beneficiaries against the loss of the insured's income, through all market conditions. Generally the financial objective for term insurance is Protection/Income Replacement, although this can also apply to permanent coverage.
2. **Income** – Seeks to earn income through holdings of bonds and income yielding securities.
3. **Growth** – Seeks to achieve growth of capital through an investment in securities.
4. **Diversified** – Financial objective options selected conform with recommendation of company approved Asset Allocation Model or 100% is allocated to the Conservative Balanced or Flexible Managed portfolio.

C. POLICYOWNER'S INCOME/EXPENSES/DURATION OF LIABILITIES – Complete all fields for all product types.

1. What are policyowner's monthly expenses (e.g., food, medical expenses, rent/mortgage, revolving debt, property taxes, transportation, utilities, entertainment and other recurring living expenses)? $_____
   Annual Income (1) $_____

(1) Annual Income – Policyowner's total annual income (earned and unearned), including salary, pension, investment returns, etc.

Duration of Liabilities - *Please select at least one option below.*

Please provide the amount of debt the policyowner is required to repay below for the indicated time periods. Debt includes mortgages, credit cards, loans, etc. For example, if the policyowner is in year 1 of a 20-year mortgage, the current balance should be noted on the "more than 10 years" line.

☐ None Less than 5 years: $_____ Between 5 and 10 years: $_____ More than 10 years: $_____

D. POLICYOWNER'S EDUCATION/MARITAL STATUS/OCCUPATION – Complete for non-term product types only.

1. Education level (Check only highest level of education.):
   ☐ Attended primary/high school ☐ High school graduate ☐ Technical or vocational school
   ☐ Attended college ☐ College graduate ☐ Post graduate work
2. Employment Status (Check only one.):
   Employed: ☐ Full time ☐ Part time ☐ Yes
   Not employed: ☐ Retired ☐ Student ☐ Unemployed
3. Marital status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Complete if policyowner is other than the proposed insured.

4. Occupation _____
5. Employer_____
   Street _____ Suite _____
   City _____ State _____ Zip _____

E. POLICYOWNER'S HOUSEHOLD INCOME/WORTH/LIQUIDITY NEEDS – Complete for non-term product types only.

1. What is the policyowner's:

Household Income (2) $_____ Net Worth (4) $_____

Existing Assets (3) $_____ Liquid Net Worth (5) $_____

(2) Household Income – Policyowner's household members' total annual income (earned and unearned) including salary, pension, investment returns, etc.

(3) Existing Assets – For the policyowner (individual) it would be the total value of all possessions, such as stocks, bonds, bank accounts, mutual funds, life insurance cash value, real estate and other investments. This includes existing deferred variable annuities.

(4) Net Worth – The value of the policyowner's assets minus liabilities. For an individual, it would be the total value of existing assets, such as stocks, bonds, bank accounts, mutual funds, cash value of life insurance, annuities, real estate, and other investments minus all outstanding liabilities such as a mortgage, loans, taxes and credit card balances.

(5) Liquid Net Worth – That part of the policyowner's net worth held in cash or easily convertible to cash, such as money market fund shares, bank deposits or marketable securities.

Liquidity Needs-*Both questions must be completed in their entirety.*

1. After purchasing this policy will the policyowner have sufficient income and liquid assets to meet monthly living expenses (i.e. food, medical expenses, rent, revolving debt, taxes, transportation and utilities) in a financial emergency? ☐ Yes ☐ No
2. Does the policyowner anticipate negative material changes to any of the following (*Select a response for each item below. Provide an explanation for each "Yes" response.*):

Annual Income ☐ Yes ☐ No _____

Financial Situation and Needs ☐ Yes ☐ No _____

Existing Assets ☐ Yes ☐ No _____

Liquidity Needs ☐ Yes ☐ No _____

Liquid Net Worth ☐ Yes ☐ No _____

F. POLICYOWNER'S ADDITIONAL PAYMENT INFORMATION – Complete for non-term product types only.

Policyowner's total first year payments planned in addition to scheduled/target premiums: $_____

G. POLICYOWNER'S INVESTMENT EXPERIENCE – Complete for non-term product types only.

Indicate the number of years of experience the policyowner has in any of the following that apply.

Equities _____ Bonds _____ Options _____ Futures _____ Mutual Funds _____ Annuity/Life _____ ☐ None

H. POLICYOWNER'S TAX BRACKET – Complete for non-term product types only.

Policyowner's current federal tax bracket: ☐ 10% ☐ 12% ☐ 22% ☐ 24% ☐ 32% ☐ 35% ☐ 37%

I. POLICYOWNER'S RISK TOLERANCE – Complete for non-term product types only.

☐ **Conservative** – Prefer little risk and low volatility in return for accepting potentially lower returns. Minimizing exposure of principal to loss or fluctuation is very important.

☐ **Moderately Conservative** – Willing to take some risk to seek enhanced returns. Reduced exposure of principal to loss or fluctuation is important.

☐ **Moderate** – Willing to assume an average amount of market risk and volatility—or loss of principal—to achieve higher returns.

☐ **Moderately Aggressive** – Willing to assume an above-average amount of risk and volatility—or loss of principal—to take advantage of potentially higher return opportunities.

☐ **Aggressive** – Willing to sustain substantial volatility—or loss of principal—and assume a high level of risk in pursuing higher returns.

J. POLICYOWNER'S VARIABLE PRODUCT ATTESTATIONS – A response is required for each question - variable product types only.

If I applied for variable life insurance, I acknowledge the following:

1. This application is submitted for the purchase of life insurance. ☐ Yes ☐ No
2. Premiums are payable on this policy for the duration of the policy, but that the policy offers the flexibility of paying premiums more or less frequently. ☐ Yes ☐ No
3. The flexibility of premium payments offered by this policy is not a guarantee that the need to make premium payments will stop or abbreviate automatically at some point in the future. ☐ Yes ☐ No
4. Willing to assume an above-average amount of risk and volatility or loss of principal to take advantage of potentially higher return opportunities. ☐ Yes ☐ No
5. The policy's cash values and death benefits can be lower if the policyowner pays premiums less frequently, or late, or in smaller amounts. ☐ Yes ☐ No
6. The policyowner is an associate of a broker/dealer. ☐ Yes ☐ No

K. PRODUCER RECOMMENDATION – Check the box below that corresponds to the product type recommended.

For the producer only. Please provide the reason you are recommending this transaction and list any other information provided by the consumer which, in your reasonable judgment, is relevant to the suitability of the transaction.

Product type recommended (check applicable box)	Favorable Characteristics	Non-favorable Characteristics
☐ Term	• Low cost • Product simplicity • Convertibility options • Guaranteed level premium • Availability of policy rider options	• Limited duration of coverage • No cash value accumulation • Premiums increase after level period
☐ Universal	• Flexible premiums • Cost-effective permanent life insurance • Availability of policy rider options • Builds cash value • Adjustable No-Lapse Guarantee period up to lifetime • Variety of death benefit options • If Indexed UL, owner can designate funds to the Index investment option	• Higher cost than Term insurance • Product complexity • Surrender charges and sales loads
☐ Variable	• Flexible premiums • Owner can designate investment funds • Availability of policy rider options • Builds cash value • Adjustable No-Lapse Guarantee period up to lifetime • Potential to build higher cash value • Variety of death benefit options	• Higher cost than Term insurance • Product complexity • Surrender charges and sales loads • Market risk

Describe the reason for your recommendation here. Include the intended use of the policy and riders. We cannot accept "None," "N/A," and blank responses.

_____

_____

_____

_____

L. POLICYOWNER'S AGREEMENTS/ATTESTATIONS

For the policyowner only. I acknowledge that:

- I believe this contract meets my insurance needs and financial objectives.
- I am willing to accept non-guaranteed elements in the policy, including variability in premium, cash value, death benefit, or fees.
- An illustration of values is available upon request.
- I am in receipt of a current prospectus for the contract, if applicable.
- If I elected the S&P 500® Indexed Account Rider, I have received the prospectus supplement.
- I have reviewed the primary purpose of this insurance transaction with my producer and identified the source of funds I will be using to pay for the premiums on this policy.
- My producer has reviewed with me the information about the type of product I am purchasing, both favorable and non-favorable, as described in the Producer Recommendation section.

Signature of Proposed Insured X _____ Date Signed _____
(Parent/Guardian when proposed insured age is less than 18.)

Signature of Policyowner X _____ Date Signed _____
(If other than the proposed insured. [Parent/Guardian when proposed insured age is less than 18.])

Signature of Producer X _____ Date Signed _____

Prudential

AGENT'S REPORT

PROPOSED INSURED: _____

A. PURPOSE OF INSURANCE

REQUIRED: Primary Purpose of Insurance (Must choose at least one. Check all that apply.)

Supplemental riders/benefits such as BAR for chronic or terminal illness do not qualify as a primary purpose of insurance.

Personal:
- ☐ Survivor income
- ☐ Supplemental retirement income
- ☐ Debt/Mortgage protection
- ☐ Estate liquidity
- ☐ Final expenses
- ☐ Asset repositioning/Wealth Transfer
- ☐ Charitable giving
- ☐ Other* _____

Executive Benefits:
- ☐ SERP/Deferred compensation
- ☐ Split dollar
- ☐ Restrictive bonus
- ☐ Executive 162 bonus
- ☐ Other* _____

Business:
- ☐ Buy-Sell/Business continuation
- ☐ Loan indemnification
- ☐ Key person
- ☐ Other * _____

OPTIONAL: Secondary Purpose of Insurance: ☐ BAR for Chronic/Terminal Illness

B. PRODUCER INFORMATION

Please identify all producers and firms involved in this sale. For split cases, please use whole percentage amounts. Include an additional page with all details if more than two producers. The producer will be paid directly for non-variable sales if no firm information is provided.

PRODUCER #1

Split commission %: _____

Producer name: _____ GA name: _____

Producer contract number: _____ GA contract number: _____

Producer Social Security number: _____ GA Employer Identification Number: _____

Producer e-mail for electronic policy delivery (if requested): _____ Case manager e-mail: _____

PRODUCER #1 FIRM

Complete only if producer #1 is acting on behalf of a firm (Both must be properly licensed and appointed for the sale.)

Firm name: _____ Firm contract number: _____

Firm Employer Identification Number: _____

PRODUCER #2

Split commission %: _____

Producer name: _____ GA name: _____

Producer contract number: _____ GA contract number: _____

Producer Social Security number: _____ GA Employer Identification Number: _____

PRODUCER #2 FIRM

Complete only if producer #2 is acting on behalf of a firm (Both must be properly licensed and appointed for the sale.)

Firm name: _____ Firm contract number: _____

Firm Employer Identification Number: _____

C. CASE DETAILS

Who is responsible for the requirement ordering?

Age and amount requirements: ☐ Prudential ☐ Producer/GA

Preferred Exam Vendor: ☐ APPS ☐ EMSI ☐ SMM

Attending Physician Statement (APS): ☐ Prudential ☐ Producer/GA

D. KNOWLEDGE OF PROPOSED INSURED

1. Did you see the proposed insured during the sales process? ☐ Yes ☐ No
2. Is the proposed insured a prior client? ☐ Yes ☐ No
3. Knowledge of Proposed Insured: ☐ Self ☐ Relative ☐ Know Slightly ☐ Known well for _____ Years at: ☐ Home ☐ Business
   ☐ Have never met ☐ Other (provide details on how you know the proposed insured) _____
4. If you have never met, provide how the solicitation took place: ☐ Internet or Phone Sale ☐ Direct Mail ☐ Ticket Process ☐ Referral
   ☐ Financial Planner/CPA/Attorney Recommendation ☐ Walk in ☐ Other _____

(CONTINUED)

E. SUITABILITY DECLARATIONS (VARIABLE PRODUCTS ONLY)

1. This application is submitted in the belief that the purchase of this policy is suitable for the policyowner based on the information furnished by the policyowner. ☐ Yes ☐ No
2. Reasonable inquiry has been made of the policyowner concerning the policyowner's insurance and investment objectives, financial situation and needs. ☐ Yes ☐ No
3. The policyowner is considering the purchase of this variable life insurance product as a vehicle for long-term life insurance death benefit protection. The policyowner is not using this product as an investment vehicle but may also have a need for cash accumulation. ☐ Yes ☐ No

F. SOURCE OF FUNDS (CASH WILL NOT BE PERMITTED FOR PAYMENT.)

1. **For Non-Term Policies Only:** Is this policy being funded via a premium financing loan or with funds borrowed, advanced or paid from another person or entity? **If "yes", additional disclosure form may be required.** ☐ Yes ☐ No
2. What is the source of funds used to pay premiums on this policy? (Check all that apply.):

	Initial	Future
Current income	☐	☐
CDs or savings	☐	☐
Mutual funds or brokerage account	☐	☐
Existing life insurance policy(ies) or annuity contract(s)	☐ (If selected complete questions 3 and 4)	☐ (If selected complete questions 3 and 4)
1035 Exchange	☐	☐
Other	☐ _____	☐ _____

Complete questions 3 and 4 only if using an existing Prudential or third party policy(ies) or annuity contract(s) to pay either initial or future premiums: (If more than one policy or contract provide full details in the **Remarks** section.)

3. What is the policy number(s) for the source of the premiums? _____
   Will any of the above policies cease to exist? ☐ Yes ☐ No
4. What is the form of the proceeds for the above policy(ies)? (Check all that apply.):
   ☐ Accumulated dividends ☐ Loans ☐ Partial surrender or withdrawal

G. UNDERWRITING CATEGORY QUOTED

If a contractual conversion, select the quoted rating that is equivalent to the guaranteed rating from the term contract.

☐ Preferred Best ☐ Preferred Non-Tobacco ☐ Non-Smoker Plus ☐ Non-Smoker ☐ Preferred Smoker ☐ Smoker

☐ Special Class:_____ ☐ Temporary Extra Premium (per thousand): $_____

☐ Avocation/Occupation Flat Extra Premium (per thousand): $_____ ☐ Aviation Flat Extra Premium (per thousand): $_____

H. PRUDENTIAL/PRUCO POLICIES ISSUED WITHIN 3 MONTHS

1. Has the client been issued a Prudential/Pruco policy within the past 3 months? ☐ Yes ☐ No
   If YES, provide Prudential/Pruco policy number:_____
2. Has the health, mental or physical condition of the proposed insured changed since the answers and statements were given in the above application? ☐ Yes ☐ No

I. REMARKS

J. MILITARY

1. Is the proposed insured an active duty service member of the United States Armed Forces (including National Guard and Reserve)? ☐ Yes ☐ No
2. Is the policyowner, or the person to whom this policy was sold, an active duty service member of the United States Armed Forces (including National Guard and Reserve)? ☐ Yes ☐ No

For a YES answer to J1 or J2, complete the appropriate disclosure form(s) and return to the Home Office.

K. PRODUCER'S STATEMENT

1. If replacement, are all policies to be replaced Term policies? ☐ Yes ☐ No
2. Do you intend to deliver the policy face to face? ☐ Yes ☐ No

I certify that:

- The solicitation or sale did NOT take place on a military base or other Department of Defense (DOD) installation;
- I have no knowledge of any factors which may have a negative effect on the proposed insured's insurability;
- I have given the *Important Notice About Your Application for Insurance* to the proposed insured;
- I provided the policyowner with the brochure *What Every Consumer Should Know About Life Insurance* and answered any questions they had about the purchase;
- If required by state regulation, I have read the *Important Notice Regarding Replacement* aloud to the applicant or the applicant did not wish the notice to be read aloud;
- **If this is for the sale of a variable product:** I have provided current copies of the *Privacy Notice* and the *ID Verification Notice* to all owner(s) and legal representative(s) and I have offered the client a choice of a paper prospectus, CD or an electronic prospectus and provided the client with their choice;
- **If this is for the sale of an equity-indexed product:** I have provided the owner(s) with the appropriate disclosures and marketing brochures, which highlight key features of the product;
- **If this is a replacement**: I have discussed the advantages and disadvantages of the replacement with the client and determined that the transaction is appropriate and I have completed the state-required replacement form(s);
- I have no other information, other than as previously reported, that the proposed insured has existing life insurance or annuities or that indicates this coverage may replace or change any current insurance or annuity in any company;
- If I become aware of a change in the health or habits of the proposed insured occurring after the date of the application but before policy delivery, I promise to inform the Company of the change and agree to withhold policy delivery until instructed by the company;
- **CA**: The *CA Disclosure Statement* was provided to the policyowner in accordance with CA Insurance Code section 789.8;
- **NY**: I have fully discussed and explained the life insurance features and charges including restrictions to the applicant. I represent that: (a) this life insurance is suitable and in the best interest of the applicant in accordance with New York Insurance Regulation 187, (b) at or before the time of recommendation, I provided to the applicant all disclosures required under New York insurance regulations, including disclosing, in a reasonable summary format, all relevant suitability considerations and product information, both favorable and unfavorable, that provided the basis for my recommendation, and (c) I have a reasonable basis to believe that the applicant has the financial ability to meet the financial commitments of the policy.
- **PA**: The *Disclosure Statement* as required by the Commonwealth of Pennsylvania Insurance Department was delivered to the policyowner;
- **VT**: If the policy applied for is a charitable gift, I have provided the *Charitable Life Gifts Disclosure* form to the proposed insured;
- All of the above statements are true and accurate.

➔ *Signature of producer* **X** _____ Date _____

Prudential

Request for Initial Premium (E-PAY) and/or to Establish Monthly Electronic Funds Transfer (EFT)

For Life New Business only

The Prudential Insurance Company of America
Pruco Life Insurance Company of New Jersey
Pruco Life Insurance Company
All are Prudential Financial companies.

Check all that apply: ☐ Initial premium E-Pay
☐ Establish monthly EFT

CLIENT INFORMATION

Name of insured *(first, middle initial, last name)* _____

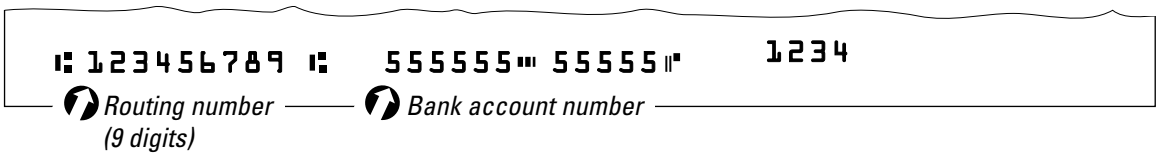
Policy number _____

INSTRUCTIONS

Use this form for Life New Business only to pay initial premium, COD, or additional monies due at policy placement using E-Pay and/or to establish monthly electronic funds transfers (EFT).

Please follow these steps:

- Complete sections 1 and 3 to request that your initial premium at point of sale or any premium or a balance due at placement be paid through E-Pay. Complete sections 2 and 3 to request monthly premium payments by EFT. Complete all sections to request both E-Pay and EFT.
- **If you are requesting initial premium or monthly EFT on more than one new policy, you must submit a separate form for each policy.**
- Print in black ink.
- Initial any corrections or changes that you make.
- Retain a copy of this form for your records.
- Refer to the check diagram below to help determine your bank routing number and bank account number.



On these pages, *I*, *me*, *my*, *you*, and *your* refer to the bank account owner. *Prudential*, *we*, and *us* refer to the Prudential company that issued the policy.

1 INITIAL PREMIUM (E-PAY) INFORMATION

Account owner type: ☐ Individual ☐ Corporate ☐ Trust ☐ Other _____

Name of account owner *(first, middle initial, last name)* _____

_____

Address _____

City/State/ZIP code _____

Bank Information

Account type: ☐ Savings ☐ Checking Withdrawal amount $ _____

Name of financial institution _____ Telephone number _____

Bank routing number *(9 digits)* _____ Bank account number _____

Copies provided to **Home Office**, **Representative**, and **Applicant**

2 MONTHLY ELECTRONIC FUNDS TRANSFER (EFT) INFORMATION

Monthly withdrawal **date**: _____ *(between the 1st and 28th of the month) **

**The monthly withdrawal date must be on or before the premium due date. If any premium withdrawal date falls on a weekend or bank holiday, the withdrawal will occur on the next business day.*

Monthly withdrawal **amount** $ _____ *(cannot exceed monthly premium unless the policy has flexible payment arrangements)*

☐ Use same bank account information in section 1. **If so, skip to Section 3**. Otherwise complete bank information below.

Account owner type: ☐ Individual ☐ Corporate ☐ Trust ☐ Other _____

Name of account owner *(first, middle initial, last name)*_____

_____

Address_____

City/State/ZIP code_____

Bank Information

Account type: ☐ Savings ☐ Checking

Name of financial institution_____ Telephone number _____

Bank routing number *(9 digits)* _____ Bank account number _____

3 AGREEMENT AND SIGNATURE *(Complete this section for all transactions.)*

As a convenience to me, I authorize Prudential to make the fund transfer(s) from my account listed above. By signing below, I understand and agree that:

For Initial Premium E-Pay

- If a withdrawal request is not honored by the financial institution, Prudential will not consider the payment to be made.
- For initial premium E-Pay, Prudential will process this withdrawal request immediately and it cannot be revoked.

For Monthly EFT

- I may cancel the authorization at any time by giving Prudential prior written notification up to three business days preceding the scheduled date of the transfer.
- I have the right to receive notice of all varying transfers. Varying transfers might occur on a date and in a different amount than the one selected, but notification will occur.
- Prudential, in its sole discretion, reserves the right to remove any policy from the electronic funds transfer payment program at any time. The payment frequency on a non-EFT basis may be changed to quarterly or another less frequent mode.
- Prudential cannot establish an electronic funds transfer program if the dividend option is to reduce premiums. In that event, Prudential will withdraw the full amount of the premiums from my account. Unless otherwise elected, any future dividends will be used to provide paid-up additional insurance, if available, or will otherwise accumulate at interest.
- If a withdrawal request is not honored by the financial institution, Prudential will not consider the payment to be made. Prudential may, in its sole discretion, resubmit the withdrawal request for collection.
- I may modify this Agreement by authorizing Prudential to make preauthorized electronic funds transfer or other forms of check withdrawals from any other bank account or financial institution that I so designate verbally, in writing, or through an automated voice response system. Any such verbal request will be confirmed by Prudential in writing.
- If I am changing the bank account that funds are withdrawn from and past premiums are due at the time Prudential receives the completed form, Prudential will draft my bank account for any past premiums due no sooner than two days and no later than eight days after receiving this form. This does not apply to variable universal or universal life policies.

For Initial Premium E-Pay or Monthly EFT

- I have 60 days from the date of the withdrawal to notify Prudential of any errors related to a transfer under this agreement.
- Except as required by the Electronic Funds Transfer Act and Regulation E, Prudential will not be liable for any exemplary, special, consequential, punitive, indirect or incidental damages, regardless of whether any claim is based on a contract or whether any such damages were foreseeable.

X_____ _____

Account owner's signature *Date (month/day/year)*

Copies provided to **Home Office**, **Representative**, and **Applicant**

Prudential

CONSENT FOR ELECTRONIC POLICY DELIVERY

The Prudential Insurance Company of America
Pruco Life Insurance Company of New Jersey
Pruco Life Insurance Company
All are Prudential Financial companies

POLICY NUMBER (IF KNOWN):_____

PROPOSED INSURED:_____

TERMS AND CONDITIONS, ELECTRONIC SIGNATURE, AND ELECTRONIC DELIVERY CONSENT

THE FOLLOWING TERMS AND CONDITIONS GOVERN ELECTRONIC DOCUMENT DELIVERY FOR LIFE INSURANCE PRODUCTS WITH PRUDENTIAL.

Your consent is voluntary. In order to receive and submit life insurance documents electronically, you must first consent to electronic delivery and submission of documents. Read the following terms and conditions and if you wish to consent to electronic delivery and submission, complete the Electronic Policy Delivery Contact Information and Signatures sections below and return the form to your representative. If you do not wish to sign your documents online or receive documents electronically, do not complete or sign this form. Not all life insurance policies are eligible to be delivered electronically.

By completing the Electronic Policy Delivery Contact Information and Signatures sections, I confirm the following statements:

- I consent to applying an electronic signature to all forms signed during the life insurance policy process and to electronic delivery of all records, including any policy issued, along with all disclosures, confirmations, statements and other communications permitted by law to be sent electronically.
- I agree that this consent is effective on the date I affix my signature below.
- I understand that I have the right to withdraw such consent at any time by contacting my representative or Prudential at www.prudential.com/myaccess.
- I understand that I can opt out of electronic delivery and usage of electronic transmissions and records at any time by contacting my representative or Prudential at www.prudential.com/myaccess.
- I understand that the policy is not complete until all signatures (including those by me, the representative, and other authorized individuals, if required) are captured and the policy documents are submitted to Prudential.
- I confirm that the contact number provided for the delivery of an authentication code belongs to me.
- I consent to receiving an automated message (voice or text) containing an authentication code via the delivery method selected.
- I understand that I will receive an email with a link that will allow me to access electronically delivered documents. I further understand that I have 90 days to view and electronically sign the documents, unless the company voids the transaction, the insured and/or policyowner declines to sign the documents, or all parties sign the documents. Once voided, declined, or signed the electronically delivered documents will be accessible for 14 days. I have the option to print or save copies of the documents during this period.
- I have the option to receive one free paper copy of any electronically transmitted record, if requested, by contacting my representative or Prudential at www.prudential.com/myaccess.
- I understand that the proposed insured and the policyowner (if different than the insured) will receive the above-mentioned email link at the email address(es) provided in the Electronic Policy Delivery Contact Information section.
- I understand that in the event my personal contact information changes or if I detect any errors in the information I've provided, I must immediately notify Prudential of the changes/error by contacting my representative or Prudential at www.prudential.com/myaccess.
- I understand that at the time I attempt to access my documents electronically, I must have access to the authentication code delivery contact number and authentication code delivery method populated below.
- I understand that to access my documents electronically, I must have access to a computer that is capable of supporting internet access and a compatible browser application along with a personal email address. Compatible browsers include current versions of Chrome, Mozilla Firefox, Internet Explorer for Windows, Safari, and Windows Edge. I must also have software that allows me to view PDF files, such as Adobe Reader or a browser plug in.

By signing below, you agree to be legally bound as if you had signed the electronically delivered life insurance policy and other documents with a handwritten signature, and you acknowledge that you have reviewed and agree to the above terms and conditions.

Your electronic signature can only be affixed to a document using your confidential password. Your signature is never stored by Prudential for use on another document.

You may retain a copy of these Terms and Conditions for your records. If you have any questions, please contact your representative.

Prudential's contact information can be found at www.prudential.com/myaccess.

The email address(es) provided will receive a confirmation email from ili.lnb.support.edelivery@prudential.com and/or your financial professional. The life insurance policy and other documents may be delivered electronically when the following requirements have been met:

1. *Consent for Electronic Policy Delivery* (ORD 115309) is fully completed, signed by the insured and policyowner (if different than the insured), and submitted to the Company.
2. The insured and policyowner (if different than the insured) receive and complete the validation email sent to the email address(es) provided to the Company.
3. The signing producer has a valid electronic delivery agreement in place with the Company.

ELECTRONIC POLICY DELIVERY CONTACT INFORMATION

The email address(es) provided will only be used for electronic policy delivery. The authentication code delivery contact number and delivery method will only be used to deliver an authentication access code, which is required to access your electronic policy package. The email address(es) and contact information may differ from the information provided on the Application for Life Insurance.

A. Proposed Insured Electronic Policy Delivery Preferences

1. Email address: _____

2. Authentication code delivery method: ☐ Text ☐ Voice Call

3. Authentication code delivery contact number: _____

B. Policyowner Electronic Policy Delivery Preferences (complete if policyowner is different than proposed insured**)**

1. Email address: _____

2. Authentication code delivery method: ☐ Text ☐ Voice Call

3. Authentication code delivery contact number: _____

Definitions: The term "Company" refers to the company named at the beginning of the Application for Life Insurance.

SIGNATURES

Signature of Insured **X**_____ (DATE) _____

Signature of Policyowner **X**_____ (DATE) _____

(if different than proposed insured)

Prudential

Instructions for Completion of Application of Life Insurance

For ALL cases: It is the responsibility of the financial professional to complete and sign the individual application *Agent's Report* (ORD 114119–IND for Prudential financial professionals or ORD 114120–IND for Third Party financial professionals). Do not provide the *Agent's Report* directly to the client.

BEFORE SUBMITTING THE APPLICATION FOR LIFE INSURANCE

- ❑ Confirm that you are appropriately licensed and appointed in the applicable state(s).
- ❑ Refer to the *Product Availability by State* listing on www.pruxpress.com for all product and rider availability.
- ❑ Verify you have the correct state-specific version of the application and other forms, as applicable, for the state you are writing in.
- ❑ Insert the proposed insured's name and, if applicable, policy number on all forms.
- ❑ Provide the *Important Notice About Your Application for Insurance* (ORD 96200B), the *Department of Financial Services of the State of New York - Definition of Replacement* (COMB 98774), and the *What Every Consumer Should Know About Life Insurance* brochure to the proposed insured.
- ❑ Provide the *Privacy Notice* to the proposed insured or proposed policyowner(s), if different than the proposed insured, on ALL variable cases.
- ❑ Complete ALL applicable sections, supplements and agreements in **BLACK ink only** with clear and legible handwriting. Make sure to initial all changes. Incomplete applications will not be reviewed for underwriting. **NOTE: Applications should be completed with the assistance of the financial professional and not solely by the client.**
- ❑ Encourage the client to sign an *Authorization to Disclose Information on Which Underwriting Decision Is Made to Insurance Agent and/or Producer* (ORD 112719A for Prudential financial professionals) or *Authorization to Disclose Information to General Agent or Broker* (ORD 112719 for Third Party financial professionals).
- ❑ Complete the IRS tax certification and provide the state in which the owner is signing the application on page 6 of the *Life Insurance Application*. **Obtain all required signatures on the *Application*.**
- ❑ Provide an alternate mailing address under "Premium" (section C) if the proposed policyowner is not the premium notice recipient. A P.O. box address is acceptable.
- ❑ Enter an alternate mailing address under "Special Requests" (section H) when the proposed insured is not the policyowner nor the premium notice recipient, and mail cannot be delivered to the proposed insured's residential address provided under "Proposed Insured" (section A). A P.O. box address is acceptable.
- ❑ Complete all information requested on the *Authorization, Acknowledgement and Limited Insurance Agreement* (ORD 96200F for Prudential financial professionals) or the *Authorization to Release Information* (ORD 96200C for Third Party financial professionals).
- ❑ Review "When submitting a prepayment" below if you are collecting a prepayment under the terms of the Limited Insurance Agreement (LIA).
- ❑ Obtain **ALL** necessary signatures (proposed insured and proposed policyowner(s), if different than the proposed insured), titles, and dates, where applicable.

FOR NON-FACE-TO-FACE SALES:

The writing financial professional must collect the application information with both the proposed insured and the proposed policyowner(s), if different than the proposed insured.

- ❑ Select "NO" in section D, Question #1 of the *Agent's Report*, noting that the financial professional did NOT see the proposed insured during the sales process.
- ❑ **Refer to the *Prudential's Guide to Non-Face-to-Face Sales* on www.pruxpress.com for eligibility requirements and additional information.**

WHEN USING FOR A POST-ISSUE TRANSACTION:

- ❑ Use "Special Requests" (section H) on the *Application for Life Insurance* for all policy change and term conversion requests.
- ❑ Include any required special wording, if provided by the Home Office.
- ❑ Use the Request for *Policy Change Supplement* (ORD 96200 CHG) ONLY when:
  - a. The existing policyowner of the policy being converted or changed is not the proposed policyowner on the new or changed policy; or
  - b. The rights restriction requires the beneficiary to sign all requests; or
  - c. There is a collateral assignee.
- ❑ Submit the initial premium amount for all contractual conversions, regardless of coverage amount.

WHEN SUBMITTING A PREPAYMENT:

- ❑ Complete a *Limited Insurance Agreement* (Limited Insurance Agreement section of the ORD 96200F for Prudential financial professionals or ORD 96200A for Third Party financial professionals).
- ❑ Always obtain **ALL** necessary signatures (proposed insured and policyowner(s), if different than proposed insured.
- ❑ Complete the *Request for Initial Premium (E-PAY) and/or to Establish Monthly Electronic Funds Transfer (EFT)* (ORD 114416), OR Instruct the payor to make the check payable to "Prudential Insurance Company".

NOTE: The total death benefit payable under all LIAs combined is the amount applied for, up to a maximum of $1,000,000.

DO NOT:

X Waive any of our requirements or information we request as you do not have that authority.

X Guarantee or imply that Prudential will provide insurance.

X Use correction fluid/tape.

X Accept prepayment if:

- Submitted in the form of cash.
- The check is made payable to you or with the payee field left blank.
- The proposed insured is unable to certify the health attestations.
- The proposed insured's age is greater than 75 years.
- The total amount of insurance requested in all applications on the proposed insured is greater than $5,000,000.

Prudential

APPLICATION FOR LIFE INSURANCE

PART 1

☑ Pruco Life Insurance Company of New Jersey
☐ The Prudential Insurance Company of America
Both are Prudential companies.
Corporate Offices, Newark, New Jersey

POLICY NUMBER (IF KNOWN):_____

A. PROPOSED INSURED (POLICY OWNER UNLESS SECTION D IS COMPLETED)

1. Name: _____
2. Previous name (if changed in the last 5 yrs.): _____
3. Social Security number: _____ 4. State of birth (Country if not U.S.): _____
5. Gender: ☐ Female ☐ Male 6. Date of birth: _____ 7. Date policy to Save Age? ☐ Yes ☐ No
8. Are you a permanent, legal US resident? ☐ Yes ☐ No
   If No, provide country of legal residence, type and number of visa, expiration date and length of US residence **:**
   _____
9. Driver's license issuing state: _____ Number: _____ Expiration date: _____
   If None, why not? **:** _____
10. Residence address (No PO boxes): Street _____ Apt _____
    City _____ State _____ ZIP _____
11. e-mail address: _____
12. Home telephone number: _____ Business telephone number (ext.): _____
13. Current employer name: _____
    Business address: Street _____ Suite _____
    City _____ State _____ ZIP _____
14. Occupation: _____
    Duties: _____
15. Earned annual income $_____ Unearned annual income $_____ Net worth $_____

B. PLAN OF INSURANCE

1. Amount of insurance applied for: $_____ **If greater than $1,000,000 for ages 81 and older or $2,500,000 for ages 71-80 or $5,000,000 for ages 70 and younger, complete *Financial Supplement*.**
2. Product applied for:
   - ☐ Term Essential®: ☐ 10 ☐ 15 ☐ 20 ☐ 30
   - ☐ Term Elite®: ☐ 10 ☐ 15 ☐ 20 ☐ 30
   - ☐ PruLife® Custom Premier II (PCP II) **Complete the *Variable Supplement.***
   - ☐ PruLife® Founders Plus (PFP) **Complete the *PFP Supplement.***
   - ☐ PruLife® Index Advantage (IAUL) **Complete the *IAUL Supplement.***
   - ☐ PruLife® Essential Universal Life (EUL)
   - ☐ PruLife® Universal Protector (UL Protector)
   - ☐ VUL Protector℠ (VULP) **Complete the *Variable Supplement.***
   - ☐ Other: _____
3. For **UL and VUL products only**: Death Benefit type: ☐ Type A (Level) ☐ Type B (Variable) – **N/A for UL Protector**
   ☐ Type C (Return of Premium) – **N/A for UL Protector & VULP.** – Interest rate: _____%
4. For **UL and VUL products only**: Definition of life insurance:
   ☐ Cash Value Accumulation Test (CVAT) ☐ Guideline Premium Test (GPT)
5. Requested Optional Benefits: (Not all benefits are available for all products.):
   - ☐ Waiver of Premium/Enhanced Disability Benefit
   - ☐ Acceleration of Death Benefit (Living Needs Benefit)
   - ☐ Accidental Death Benefit: Amount $_____
   - ☐ BenefitAccess Rider **Complete *BenefitAccess Rider Supplement.***
     If applicable, **Select Max Monthly Benefit Percentage ☐ 2% or ☐ 4%**
   - ☐ Overloan Protection Rider
   - ☐ Child Rider **Complete *Child Rider Supplement.***
   - ☐ Automatic Premium Loan
   - ☐ Other Riders/Benefits (indicate amount where applicable):
     _____

C. PREMIUM

1. Send notices (check one): ☐ Policyowner ☐ Other recipient: _____
   Send notices (check one): ☐ Policyowner's residence ☐ Other address:
   Street _____ Apt _____
   City _____ State _____ ZIP _____
2. Premium payment mode: ☐ Annual ☐ Semiannual ☐ Quarterly ☐ Monthly – Electronic Funds Transfer
3. **For non-term plans**, billed premium: $_____

D. OWNER (COMPLETE IF OWNER IS OTHER THAN THE PROPOSED INSURED)

For multiple owners, details are to be listed in Special Requests, section H.

1. Name of owner: ______
2. Social Security/Tax identification number (SSN/TIN): ______
3. Residence address (No PO boxes): Street ______ Apt ______
   City ______ State ______ ZIP ______
4. Owner's email address: ______

5a. For trust owner: **Complete the *Trustee Statement and Agreement* (COMB 86044).**
Trust date: ______
Trustee(s) ______
Type: ☐ Revocable ☐ Irrevocable ☐ Qualified Retirement Plan Trust ☐ Welfare Benefit Trust

5b. For business owner: **Complete the *Business Supplement.***
Form: ☐ Corporation ☐ Partnership ☐ Sole proprietorship ☐ Other: ______
☐ S Corporation ☐ LLC ☐ Tax exempt

5c. For personal owner:
Total insurance program: Currently in-force: $ ______ Pending applications: $ ______
Relationship to Proposed Insured: ______ Date of birth: ______
Earned annual income: $ ______ Unearned annual income: $ ______ Net worth: $ ______

E. BENEFICIARY DETAILS

If insurance is for business purposes, also complete the Business Insurance Supplement. If beneficiary is a trust, provide name of trust and trustee(s), date of trust and if trust is revocable or irrevocable. If beneficiary is a business, please list name of business, city and state where located and the form of business.

Name: First	Middle	Last	Relationship to Proposed Insured	Age	Beneficiary Class Primary	Beneficiary Class Secondary/Contingent
					☐	☐
					☐	☐
					☐	☐
					☐	☐

F. INSURANCE HISTORY

1. Do you have any existing life insurance or annuities? ☐ Yes ☐ No
   Note: Existing coverage includes any life insurance policies that have been assigned, sold or transferred.
2. Will this insurance replace* any existing insurance or annuity? ☐ Yes ☐ No
3. List the following details for all existing coverage. (List only annuities to be replaced*, list all in force life insurance):

Insurance Company	Face Amount	Type	Product	To Be Replaced?*	1035 Exchange?
______	$ ______	☐ Group ☐ Individual	☐ Annuity ☐ Life	☐ Yes ☐ No	☐ Yes ☐ No
______	$ ______	☐ Group ☐ Individual	☐ Annuity ☐ Life	☐ Yes ☐ No	☐ Yes ☐ No
______	$ ______	☐ Group ☐ Individual	☐ Annuity ☐ Life	☐ Yes ☐ No	☐ Yes ☐ No
______	$ ______	☐ Group ☐ Individual	☐ Annuity ☐ Life	☐ Yes ☐ No	☐ Yes ☐ No
______	$ ______	☐ Group ☐ Individual	☐ Annuity ☐ Life	☐ Yes ☐ No	☐ Yes ☐ No

*Replace or replaced means that the insurance being applied for may replace or cause a change in any existing insurance or annuity with any company, including the lapse or surrender of the existing policy, or the use of funds or values from the existing policy to pay for the new policy.

4. Are you applying for or reinstating life insurance with any company? ☐ Yes ☐ No
   ***If Yes, give company name, amount applied for and total amount to be placed, including this application*:**
   ______
   ______
5. Have you had life or health insurance declined, postponed, rated or issued with an increased premium? ☐ Yes ☐ No
   ***If Yes, give company name, type of insurance, date, action taken and reason for action*:**
   ______
   ______

(CONTINUED)

F. INSURANCE HISTORY (CONTINUED)

6. Is the proposed insured or proposed owner considering the transfer or sale to a life settlement company or other investor of: policy ownership; or, any interest in the policy benefits, either directly as a named beneficiary or indirectly as a beneficiary or owner of a trust or other entity? ☐ Yes ☐ No

If Yes, provide details : _____

_____

G. GENERAL INFORMATION

1. In the past five years, have you flown as a pilot, student pilot or crew member or do you intend to become a pilot? ☐ Yes ☐ No
2. In the past five years, have you participated in any activities such as motorized vehicle racing, SCUBA diving, mountain climbing, skydiving, extreme sports such as BASE jumping, bungee jumping or cave exploration, or do you intend to? ☐ Yes ☐ No

   If Yes, to Question 1 or 2 above, complete the appropriate Supplement.
3. Have you ever used tobacco or any other nicotine products such as cigarettes, cigars, pipe, chewing tobacco, snuff, nicotine gum or nicotine patch? ***If Yes, provide details*** : ☐ Yes ☐ No

Product Type(s)	Date Last Used	Frequency of Use

4. In the past five years, have you:
   a. had your driver's license denied, suspended or revoked? ☐ Yes ☐ No
   b. been convicted of or pled guilty to driving under the influence of alcohol and/or drugs? ☐ Yes ☐ No
   c. been convicted of or pled guilty to any moving violations? ☐ Yes ☐ No
5. Within the past 10 years, have you been convicted for any crime and/or are you currently charged with any crime? ☐ Yes ☐ No
6. Will you live or travel outside the United States within the next 12 months? ☐ Yes ☐ No

   Details required include location (city/country), frequency, duration and purpose of each trip.
7. Give complete details of any "Yes" answers for questions 4 – 6, including question number and appropriate details:

Question #	Details

H. SPECIAL REQUESTS

PART 2

A. PERSONAL PHYSICIAN INFORMATION

Name _____

Address: Street _____ Suite _____

City _____ State _____ ZIP _____

Telephone number: _____ Date last seen: _____

Reason last seen: _____

If more than one personal physician, provide details in section D number 6.

B. PHYSICAL MEASUREMENTS

1. Height: _____ feet _____ inches Weight: _____ pounds
2. Within the last 12 months, have you had a change of weight (gain or loss) of more than 10 pounds? ☐ Yes ☐ No
   If Yes, provide details **:** _____

C. FAMILY HISTORY

1. Have any immediate family members (mother, father, brother, sister) been diagnosed with or died from coronary artery disease, cerebrovascular disease, diabetes or cancer before age 70? ☐ Yes ☐ No
   If Yes, provide details including which member and medical condition, age at diagnosis, and age at death (if applicable) **:**

2. **Father:** Current age _____ or Age at death: _____ **Mother:** Current age _____ or Age at death: _____

D. MEDICAL INFORMATION

1. Has a member of the medical profession ever treated you for or diagnosed you with:
   a. high blood pressure, chest pain, a heart attack, coronary artery disease, a heart valve disorder, a heart murmur, an irregular heart beat, cerebrovascular disease, a stroke, circulatory disease, an aneurysm or any disease of the heart or blood vessels? ☐ Yes ☐ No
   b. anemia or other abnormality of the blood (other than HIV)? ☐ Yes ☐ No
   c. a polyp, cyst, tumor, cancer, leukemia, melanoma, lymphoma or Hodgkin's disease? ☐ Yes ☐ No
   d. diabetes, high blood sugar, glucose intolerance or other endocrine disorder? ☐ Yes ☐ No
   e. anxiety, depression, or any other mental or psychiatric illness? ☐ Yes ☐ No
   f. Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)? ☐ Yes ☐ No
   g. any sexually transmitted disease? ☐ Yes ☐ No
   h. asthma, emphysema, cystic fibrosis, sleep apnea, sarcoidosis, tuberculosis or any other disorder of the lungs or respiratory system? ☐ Yes ☐ No
   i. a seizure, epilepsy, multiple sclerosis, Parkinson's disease, muscular dystrophy, cerebral palsy, paralysis, Alzheimer's disease or any other disorder of the brain or nervous system? ☐ Yes ☐ No
   j. an ulcer, hepatitis, cirrhosis, pancreatitis, ulcerative colitis, Crohn's disease or any other disorder of the esophagus, liver, stomach or intestines? ☐ Yes ☐ No
   k. nephritis, polycystic kidney disease or any other disorder of the bladder, kidney, urinary tract or prostate? ☐ Yes ☐ No
   l. arthritis, gout, back trouble, or any disease or disorder of the joints, muscles or bones? ☐ Yes ☐ No
   m. lupus, rheumatoid arthritis, chronic fatigue syndrome, fibromyalgia, or any other disease or disorder of the autoimmune system? ☐ Yes ☐ No
2. Have you ever used:
   a. cocaine, crack, marijuana, heroin, Ecstasy, PCP, LSD, methamphetamine, any other hallucinogenic drug or controlled substance? ☐ Yes ☐ No
   b. amphetamines, barbiturates, sedatives, opiates or methadone, or controlled substance except as prescribed by a physician? ☐ Yes ☐ No
3. Have you had or been advised to have treatment or counseling for alcohol or drug use or been asked to reduce or eliminate their usage? ☐ Yes ☐ No
4. Other than what has already been disclosed, within the past 5 years, have you:
   a. requested or received disability or compensation benefits? ☐ Yes ☐ No
   b. been a patient in a hospital or other medical facility, other than for normal childbirth? ☐ Yes ☐ No
   c. had any other disease, disorder or condition? ☐ Yes ☐ No
   d. been advised to have surgery, medical tests or diagnostic procedures (other than for HIV)? ☐ Yes ☐ No
5. Are you currently receiving medical treatment or taking any other medication or herbal supplement that has not already been disclosed? ☐ Yes ☐ No

(CONTINUED)

D. MEDICAL INFORMATION (CONTINUED)

6. Give complete details of any "Yes" answers for questions 1-5, including: **Question number, diagnosis, date of onset and recovery, medication/treatment prescribed and the name, address and telephone number of all attending physicians and hospitals.**

Question #	Diagnosis	Date of Onset	Date of Recovery	Medication/ Treatment Prescribed	Physician/Hospital Name, Address & Phone Number

For additional medical details, use Overflow Details Supplement (ORD 96200OD-2010 NEW YORK). This Part 2 will be attached to and made a part of the policy when issued.

AGREEMENTS

By signing this form, I have carefully reviewed the application including all supplements attached to the policy, and I agree to the following:

- To the best of my knowledge and belief, the statements in this application are complete, true and correctly recorded.
- Except for failure to pay premium, the validity of this policy will not be contested after it has been in force during the insured's lifetime for two years from the date it takes effect.
- I confirm that if I have requested the Acceleration of Death Benefits (Living Needs Benefit) rider, I have read the disclosures in the brochure **(ORD 87246 NY);** and am aware that **(1) receipt of accelerated death benefits may affect eligibility for public assistance programs and may be taxable; and (2) a discount is applied to determine any accelerated death benefit payable and a $150 administrative charge will be deducted at the time of payment.**
- My original signature has been affixed to this application. The original application will be retained by the Company and I will receive a copy identical in form and substance to the original, attached to and will become a part of my policy.
- Any policy issued on this application shall not take effect until after all of the following conditions are met:
  - A payment equal to the full first required premium is received by the Company within the lifetime of the proposed insured. A payment will only be considered to be received if one of the following valid items is received by the Company: (i) a check in the amount of the full first required premium; (ii) a completed and signed payment form for the first full premium; or (iii) any other form of payment acceptable to the Company.
  - The form of payment submitted is honored. If payment is made by credit/debit card, wire transfer or automatic bank draft, no premium is considered to be honored until the Company actually receives the funds unless otherwise provided by applicable law.
  - A signed copy of this Application is received by the Company.
  - The Owner has personally received the policy during the lifetime of and while the health of the Proposed Insured is as stated in this application.
- Only an officer of the Company with the rank or title of Vice President may make or alter any contract or agree not to enforce any of the rights of the Company, and then only in writing. **No producer or medical examiner is authorized to accept risks, pass on insurability, make or alter contracts, or waive any of the other rights or requirements of the Company.** Notice to or knowledge imputed to any producer or medical examiner will not be notice of or knowledge to the Company unless it is set out in writing in this application.

SIGNATURES

Owner's Tax Certification (check boxes **ONLY** if applicable**):**

Under penalties of perjury, I certify that the taxpayer identification number (TIN) I have listed on this form is my correct TIN. I further certify that I am a U.S. person (including resident alien), I am not subject to backup withholding under Section 3406(a)(1)(C) of the Internal Revenue Code, and I am not subject to FATCA reporting.

☐ I have been notified by the Internal Revenue Service that I am subject to backup withholding due to the underreporting of interest or dividends

☐ I am subject to FATCA reporting

☐ I am not a U.S. person (including resident alien). You must submit the applicable Form W-8 (BEN, BEN-E, ECI, EXP or IMY). In most cases, Form W-8BEN will be the appropriate form.

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Signed at (**STATE**) _____ on (**DATE**) _____

➔ Signature of proposed insured **X** _____

If policyowner is different from the proposed insured:

For a personal policyowner(s):

➔ Signature of policyowner(s) **X** _____

For an entity policyowner(s) (i.e., trust, business):

Name of entity _____

➔ Signature of officer/trustee(s) **X** _____

Title of officer/trustee(s) _____

➔ **Signature of producer** **X** _____

Prudential

Important Notice About Your Application for Insurance

The Prudential Insurance Company of America
Pruco Life Insurance Company of New Jersey

The words "you" and "your" refer to the primary proposed insured and policyowner or applicant, if other than the primary proposed insured.

This notice tells you about the information practices we will employ in evaluating your application for insurance.

UNDERWRITING INFORMATION AND PRACTICES

We review information about you to decide if you're eligible for coverage. Your application is the primary source of this information. We may also obtain information about you from the following other sources: any required medical examination; the MIB, Inc.; and doctors, hospitals, health care providers, pharmacy benefit managers, consumer reporting agencies, publicly accessible sources, or any other organizations or persons who have information about you or your mental or physical health. In addition, we may request that an investigative consumer report be prepared in which information about your character, general reputation, personal characteristics, and mode of living is obtained through interviews with your neighbors, friends, associates, acquaintances, or others who may have knowledge concerning such items of information. You may ask to be interviewed in connection with the preparation of the investigative consumer report.

Your eligibility for coverage will depend on the information we collect, the application process we use to collect that information, and our underwriting risk assessment. Eligible proposed insureds who submit information through our telephone interview process may qualify for an accelerated underwriting program. This program is available for select products and could result in coverage being issued without a medical exam, which would otherwise be required. We strive for consistent results in our underwriting decisions regardless of the application process used. However, differences can occur, which could affect your premium. For example, if the insurance exam provides information not otherwise available, your policy costs could be higher than they would have been if underwritten through our accelerated underwriting program. It's important to review any questions you have about our underwriting process with your financial professional.

DISCLOSING INFORMATION

We will treat any information we obtain or have obtained about you as confidential. We may disclose information we have collected as follows: to affiliates or third parties that perform services for us, or on our behalf, or that are providing service to you; to your doctor; to insurance regulators; to law enforcement or other governmental authorities under limited circumstances; for actuarial or research studies; or as otherwise permitted or required, with or without your authorization, by applicable law. Prudential or its reinsurers may make a brief report to the MIB, a not for profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the MIB, upon request, will supply such company with the information in its file. Information about MIB may be obtained on its website at www.mib.com.

Upon receipt of a request from you, the MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in the MIB's file, you may contact the MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734 and the toll-free telephone number is 866-692-6901.

Prudential, or its reinsurers, may also release information in its file to other life insurance companies to which you may apply for life or health insurance or to which a claim for benefits may be submitted. A consumer reporting agency that prepares a consumer report may keep the information it has gathered and disclose it to others.

We may share your personal information with affiliates so that Prudential companies can market their products and services to you, unless you opt out of such sharing. Unless you agree otherwise, we do not disclose your information to other companies for them to market their products and services to you.

YOUR RIGHT TO INFORMATION

If we do not issue the contract you requested, we will tell you and explain the reasons for our decision in writing. You have the right to make a written request within a reasonable period of time to receive additional, detailed information about the nature and scope of any investigative consumer report we request. You also have the right to request a written summary of your rights as a consumer from the consumer reporting agency that prepared the report. If you request one, a copy of any consumer report we obtained about you will be provided to you. Upon your request to the address below, we will provide you with our notice of information practices, which is a more detailed description of our information practices and your rights. You have the right to make a written request to us at the address below for access to personal information we have about you or to request that we correct, amend, or delete any information we have on record about you.

Prudential Ins. Co. of America
1600 Malone St, Suite: DTY
Millville, NJ 08332

Prudential

AUTHORIZATION TO RELEASE INFORMATION

Pruco Life Insurance Company of New Jersey
The Prudential Insurance Company of America
Both are Prudential companies.

POLICY NUMBER (IF KNOWN): _____

PROPOSED INSURED NAME (PRINT): _____

This Authorization was intended to comply with the HIPAA Privacy Rule

- I authorize any licensed physician, medical practitioner, hospital, clinic, other health care provider, pharmacy benefit manager, insurance company or producer, financial or legal advisor, government agency, MIB Inc., consumer reporting agency, or other organization or person as referenced in the Important Notice to give any information about me, or my mental or physical health to the Company and/or its authorized agents to determine my eligibility for insurance and/or benefit payment, and/or to contest coverage and/or to conduct legally permissible actuarial, audit and research activities. It also includes motor vehicle records.
- The information authorized for release includes:

  My entire medical record, including any information regarding medications used, drug and alcohol treatment, and communicable or venereal diseases, such as hepatitis, syphilis, gonorrhea, the human immunodeficiency virus (HIV), and Acquired Immune Deficiency Syndrome (AIDS), excluding psychotherapy notes.
- **For purposes of this Authorization, I hereby revoke any prior restriction on disclosure of my medical records, and authorize the release of my entire medical record to the Company, excluding psychotherapy notes.**
- This Authorization may be revoked at any time by writing us at the Customer Service Office address provided in the Important Notice. The revocation will not be valid to the extent we relied on the authorization prior to the notice of revocation. In addition, the revocation does not effect our legal rights under the policy to contest a claim or the policy itself. Revocation or alteration of this Authorization may mean that we will not be able to complete the application process and may deny a claim for insurance.
- Once disclosed to the Company, the information will no longer be protected by the Health Insurance Portability and Accountability Act, but will be protected by other applicable federal and state laws relating to the protection of personal information. Information related to alcohol and drug abuse that has been disclosed to the Company may be protected by Federal Regulations 42 CFR part 2.
- This Authorization also applies to any member of my family proposed for coverage in the application & is valid for 2 years after the date below for the purposes stated above. When used for claim purposes, it is valid for 2 years after the date below or for the duration of the claim.
- A copy of this Authorization will be provided to me or my authorized representative by my insurance representative or the Company, either at time of execution or shortly thereafter. I understand my representative can tell me how and when I will receive a copy. A photocopy of this Authorization is as valid as the original.
- Treatment, payment, enrollment in a health plan, or eligibility for health benefits may not be conditioned on signing this authorization.

SIGNATURES

- I acknowledge that I have received the **Important Notice About Your Application for Insurance**.
- I authorize the Company to retain and disclose information to the MIB, reinsurers, or for insurance underwriting, policyholder service or claim handling, to others who perform services for us, or as otherwise allowed by law. Any revocation of this authorization will not impact these rights of disclosure.

➔ Signature of proposed insured **X** _____ Date: _____
(Parent/Guardian when proposed insured age is less than 18)

Prudential

LIMITED INSURANCE AGREEMENT

Corporate Offices, Newark, New Jersey

☐ The Prudential Insurance Company of America
☑ Pruco Life Insurance Company of New Jersey
Both are Prudential companies.

THANK YOU FOR CHOOSING PRUDENTIAL FOR YOUR INSURANCE NEEDS

PART 1 – HEALTH CERTIFICATE

A premium can be collected and insurance can take effect under this Limited Insurance Agreement (the "Agreement") only if the following statement is true: To the best of my knowledge and belief, I certify and affirm that the proposed insured has not:

(1) Within the past 90 days been hospitalized or been advised by a member of the medical profession that he or she needs hospitalization for any reason (other than for normal pregnancy or well-baby care).
(2) Within the past 12 months received treatment or advice from a member of the medical profession for heart disease, chest pain, stroke or cancer (except skin).

PART 2 – TERMS AND CONDITIONS

The Company agrees to provide limited life insurance coverage under the following terms and conditions:

A. EFFECTIVE DATE OF COVERAGE

Limited insurance starts on the date all of the following requirements have been met:

1. A payment equal to the full first required premium is received at our Administrative Office within the lifetime of the person proposed for coverage under this Agreement. A payment will be considered to be received only if one of the following valid items is received at our Administrative Office: (i) A check in the amount of the full first required premium; (ii) A completed and signed payment form for the first full premium; or (iii) Any other form of payment acceptable to the Company.
2. The form of payment submitted is honored. If payment is made by credit card or automatic bank draft, no premium is considered to be honored until the Company actually receives the funds unless otherwise provided by applicable law.
3. If survivorship coverage is requested, and one proposed insured dies during the Limited Insurance Agreement coverage period and the insured who died had completed all initial medical exams and tests and was found to be insurable according to the Company's underwriting rules, a joint and last survivor policy will be offered to the surviving insured if that insured is also found to be insurable according to the Company's underwriting rules. If one proposed insured dies during the Limited Insurance Agreement coverage period and the one insured who died had not completed all initial medical exams and tests or was found to be uninsurable according to the Company's underwriting rules, the premium paid would then be refunded and no policy would be issued.
4. All application information (including, but not limited to, all information necessary to complete parts 1 & 2 of the application and any questionnaires and supplements to the application) is provided and received at our Administrative Office and any medical examination and tests required by the Company are completed and received at our Administrative Office.
5. This Agreement has been fully completed, signed and dated by the policyowner, proposed insured (if different than the policyowner) and producer.

However, if the proposed insured dies as a direct result of, independent from all other causes, accidental bodily injury within 30 days of the date payment is honored but before any exam and tests are completed, a death benefit will be paid under the terms of this Agreement. We will not pay a benefit under the preceding sentence for death caused or contributed to by: (1) infirmity or disease of mind or body or treatment for it or (2) any infection other than one caused by an accidental cut or wound.

B. END DATE OF COVERAGE

Limited insurance ends when the first of the following occurs:

1. We issue a policy as applied for and the application has been signed.
2. We deliver a policy other than as applied for. The limited insurance will end on delivery of the policy regardless of whether the policy is accepted.
3. Five days have passed after the date we mailed you a letter notifying you that we have declined to issue you a policy or that we will not provide limited insurance coverage on a prepaid basis.
4. Sixty days have passed since the Effective Date of Coverage under this Agreement, and the limited insurance provided under this Agreement has not ended for any of the reasons listed above.

If the limited insurance ends and is not replaced by a policy, we will refund the amount you paid.

C. SPECIAL LIMITATIONS

- This Agreement does not provide coverage for any riders or additional supplemental benefits which you have requested from the Company.
- The limited insurance is subject to the terms, limitations and exclusions of the policy you have requested from the Company. We will pay the death benefit under this Agreement to the beneficiary you designated to the Company.
- If benefits are payable under this Agreement, then no benefit relating to that death will be payable under any policy that is subsequently issued.
- No producer, medical examiner, or any other Company representative is authorized to accept risks or determine insurability, or to alter or waive any of the terms or conditions of this Agreement, or to waive any of the Company's rights or requirements.
- The total amount of insurance requested in all applications on the proposed insured (or if survivorship coverage is requested, both proposed insureds combined) cannot exceed $5,000,000.
- **There is no coverage under this Limited Insurance Agreement if the Health Certification is materially misrepresented. If death is due to suicide or intentionally self-inflicted injury, payment will be limited to the return of the amount paid.**

Definitions: The term "Company" refers to the company named at the beginning of the Application for Life Insurance.
My original signature has been affixed to this Agreement. The original will be retained by the Company and I will receive a copy identical in form and substance.

PART 2 – TERMS & CONDITIONS (CONTINUED)

D. AMOUNT OF COVERAGE

If the proposed insured dies, the total death benefit under this Agreement is the amount requested, up to a maximum aggregate amount of death benefit payable under this Agreement and any other Limited Insurance Agreement issued by the Company on the proposed insured of $1,000,000. The total maximum aggregate amount of death benefit payable under this Agreement and any other Limited Insurance Agreement issued by the Company on any proposed insured cannot exceed $1,000,000.

SIGNATURES

Person proposed for coverage: _____

Amount of insurance requested: $_____ Amount of prepayment: $_____

All premium checks must be made payable to the Company – do not make check payable to the producer or leave the payee blank. This agreement is valid only if the form of payment submitted is honored. If payment is made by credit card or automatic bank draft, no premium is considered to be honored until the Company actually receives the funds unless otherwise provided by applicable law.

I have read this Limited Insurance Agreement including all information on Page 1. The terms, conditions and limitations of this Agreement have been fully explained to me by the producer, and I understand and agree to them.

➔ Signature of proposed insured: **X** _____ Date: ____/____/____
(Parent/Guardian when proposed insured age is less than 18)

➔ Signature of policyowner(s): **X** _____ Date: ____/____/____
(If different from proposed insured [Parent/Guardian when proposed insured age is less than 18])

I have no personal knowledge of any factors which may have a negative effect on the proposed insured's insurability:

➔ Signature of producer: **X** _____ Date: ____/____/____

Prudential

Notice and Consent for AIDS virus (HIV) Antibody/Antigen Testing

Pruco Life Insurance Company of New Jersey
The Prudential Insurance Company of America
Corporate Offices, Newark, New Jersey

Policy number: _____

In order to evaluate your application for insurance, we request a sample of your bodily fluid(s) to test for the presence of antibodies to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. If the initial HIV test is positive for the presence of HIV antibodies, that test will be repeated. If the second test is also positive, a different test will be performed on the same bodily fluid(s) to make sure that the results of the preceding HIV tests were correct. These tests are very reliable and false positives are rare. All tests will be performed by a licensed laboratory.

All test results will be treated confidentially. They will be reported by the laboratory to us. When necessary for business reasons in connection with insurance you have or have applied for with us, we may disclose test results to others involved solely in the underwriting process such as our affiliates, reinsurers, employees or contractors. As a member of the Medical Information Bureau (MIB, Inc.), and if the test results for HIV antibodies is other than normal, we will report to the MIB, Inc. a generic code which signifies only a non-specific test abnormality. If your HIV test is normal, no report will be made about it to the MIB, Inc. The organizations described in this paragraph may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that tests have been done except as may be required or permitted by law or as authorized by you.

Notification of Test Results

If your HIV test results are negative and/or your other test results fall within normal range, no routine notification will be sent to you. If, however, your HIV test results are positive or indeterminate, or the non-HIV test results fall outside of the normal range, you are entitled to that information if you so desire. Because a medically trained person should deliver that information so that you can understand clearly what the test results mean, you are asked to list your private physician, health care provider or another person to whom the Insurer will report the test results and who may explain their meaning.

Physician or other person to whom positive or indeterminate test results will be reported:

Name _____ Address: _____

City _____ State _____ Zip _____

Meaning of Positive HIV Test Result

The HIV test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus. A positive test result does not mean that you have AIDS but that you are at significantly increased risk of developing problems with your immune system. Your private physician, a public health clinic, or an AIDS information organization in your city might provide you with further information on the medical implications of a positive test or provide for further independent testing.

Positive HIV antibody test results will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

For further information about AIDS, the meaning of HIV related test results and the availability and location of HIV counseling services call the New York State Department of Health toll-free Hotline number **1-800-541-AIDS**.

Consent for Testing and Disclosure of Test Results

I have read and I understand this Notice and Consent for AIDS virus (HIV) Antibody/Antigen Testing. I voluntarily consent to the withdrawal of my bodily fluid(s), the testing of the specimen(s) provided and the disclosure of the test results as described above. I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

_____

Name of Proposed Insured *(please print)*

_____ _____

Signature of Proposed Insured or Parent/Guardian Date signed

Prudential

Notice and Consent for AIDS virus (HIV) Antibody/Antigen Testing

Pruco Life Insurance Company of New Jersey
The Prudential Insurance Company of America
Corporate Offices, Newark, New Jersey

Policy number: _____

In order to evaluate your application for insurance, we request a sample of your bodily fluid(s) to test for the presence of antibodies to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. If the initial HIV test is positive for the presence of HIV antibodies, that test will be repeated. If the second test is also positive, a different test will be performed on the same bodily fluid(s) to make sure that the results of the preceding HIV tests were correct. These tests are very reliable and false positives are rare. All tests will be performed by a licensed laboratory.

All test results will be treated confidentially. They will be reported by the laboratory to us. When necessary for business reasons in connection with insurance you have or have applied for with us, we may disclose test results to others involved solely in the underwriting process such as our affiliates, reinsurers, employees or contractors. As a member of the Medical Information Bureau (MIB, Inc.), and if the test results for HIV antibodies is other than normal, we will report to the MIB, Inc. a generic code which signifies only a non-specific test abnormality. If your HIV test is normal, no report will be made about it to the MIB, Inc. The organizations described in this paragraph may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that tests have been done except as may be required or permitted by law or as authorized by you.

Notification of Test Results

If your HIV test results are negative and/or your other test results fall within normal range, no routine notification will be sent to you. If, however, your HIV test results are positive or indeterminate, or the non-HIV test results fall outside of the normal range, you are entitled to that information if you so desire. Because a medically trained person should deliver that information so that you can understand clearly what the test results mean, you are asked to list your private physician, health care provider or another person to whom the Insurer will report the test results and who may explain their meaning.

Physician or other person to whom positive or indeterminate test results will be reported:

Name _____ Address: _____

City _____ State _____ Zip _____

Meaning of Positive HIV Test Result

The HIV test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus. A positive test result does not mean that you have AIDS but that you are at significantly increased risk of developing problems with your immune system. Your private physician, a public health clinic, or an AIDS information organization in your city might provide you with further information on the medical implications of a positive test or provide for further independent testing.

Positive HIV antibody test results will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

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_____

Name of Proposed Insured *(please print)*

_____ _____

Signature of Proposed Insured or Parent/Guardian Date signed

Prudential

Corporate Offices
Newark, New Jersey 07102

☐ **The Prudential Insurance Company of America, or**
☑ **Pruco Life Insurance Company of New Jersey,**
Both are Prudential companies.

DEPARTMENT OF FINANCIAL SERVICES OF THE STATE OF NEW YORK - DEFINITION OF REPLACEMENT

IN ORDER TO DETERMINE WHETHER YOU ARE REPLACING OR OTHERWISE CHANGING THE STATUS OF EXISTING LIFE INSURANCE POLICIES OR ANNUITY CONTRACTS, AND IN ORDER TO RECEIVE THE VALUABLE INFORMATION NECESSARY TO MAKE A CAREFUL COMPARISON IF YOU ARE CONTEMPLATING REPLACEMENT, THE AGENT OR BROKER IS REQUIRED TO ASK YOU THE FOLLOWING QUESTIONS AND EXPLAIN ANY ITEMS THAT YOU DO NOT UNDERSTAND.

AS PART OF YOUR PURCHASE OF A NEW LIFE INSURANCE POLICY OR A NEW ANNUITY CONTRACT, HAS EXISTING COVERAGE BEEN, OR IS IT LIKELY TO BE:

(1) LAPSED, SURRENDERED, PARTIALLY SURRENDERED, FORFEITED, ASSIGNED TO THE INSURER REPLACING THE LIFE INSURANCE POLICY OR ANNUITY CONTRACT , OR OTHERWISE TERMINATED? ☐ YES ☐ NO

(2) CHANGED OR MODIFIED INTO PAID-UP INSURANCE; CONTINUED AS EXTENDED TERM INSURANCE OR UNDER ANOTHER FORM OF NONFORFEITURE BENEFIT; OR OTHERWISE REDUCED IN VALUE BY THE USE OF NONFORFEITURE BENEFITS, DIVIDEND ACCUMULATIONS, DIVIDEND CASH VALUES OR OTHER CASH VALUES? ☐ YES ☐ NO

(3) CHANGED OR MODIFIED SO AS TO EFFECT A REDUCTION EITHER IN THE AMOUNT OF THE EXISTING LIFE INSURANCE OR ANNUITY BENEFIT OR IN THE PERIOD OF TIME THE EXISTING LIFE INSURANCE OR ANNUITY BENEFIT WILL CONTINUE IN FORCE? ☐ YES ☐ NO

(4) REISSUED WITH A REDUCTION IN AMOUNT SUCH THAT ANY CASH VALUES ARE RELEASED, INCLUDING ALL TRANSACTIONS WHEREIN AN AMOUNT OF DIVIDEND ACCUMULATIONS OR PAID-UP ADDITIONS IS TO BE RELEASED ON ONE OR MORE OF THE EXISTING POLICIES? ☐ YES ☐ NO

(5) ASSIGNED AS COLLATERAL FOR A LOAN OR MADE SUBJECT TO BORROWING OR WITHDRAWAL OF ANY PORTION OF THE LOAN VALUE, INCLUDING ALL TRANSACTIONS WHEREIN ANY AMOUNT OF DIVIDEND ACCUMULATIONS OR PAID-UP ADDITIONS IS TO BE BORROWED OR WITHDRAWN ON ONE OR MORE EXISTING POLICIES? ☐ YES ☐ NO

(6) CONTINUED WITH A STOPPAGE OF PREMIUM PAYMENTS OR REDUCTION IN THE AMOUNT OF PREMIUM PAID? ☐ YES ☐ NO

IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, A REPLACEMENT AS DEFINED BY NEW YORK INSURANCE REGULATION 60 HAS OCCURRED OR IS LIKELY TO OCCUR AND YOUR AGENT OR BROKER IS REQUIRED TO PROVIDE YOU WITH THE **IMPORTANT** NOTICE REGARDING REPLACEMENT OR CHANGE OF LIFE INSURANCE POLICIES OR ANNUITY CONTRACTS. YOU WILL ALSO RECEIVE A COMPLETED DISCLOSURE STATEMENT NO LATER THAN THE TIME YOUR NEW POLICY OR NEW CONTRACT IS DELIVERED.

Date: _____ Signature of Applicant _____

Date: _____ Signature of Applicant _____

To the best of my knowledge, a replacement is involved in this transaction: ☐ YES ☐ NO

Date: _____ Signature of Agent or Broker: _____

Prudential

Corporate Offices
Newark, New Jersey 07102

☐ **The Prudential Insurance Company of America, or**
☑ **Pruco Life Insurance Company of New Jersey,**
Both are Prudential companies.

DEPARTMENT OF FINANCIAL SERVICES OF THE STATE OF NEW YORK - DEFINITION OF REPLACEMENT

IN ORDER TO DETERMINE WHETHER YOU ARE REPLACING OR OTHERWISE CHANGING THE STATUS OF EXISTING LIFE INSURANCE POLICIES OR ANNUITY CONTRACTS, AND IN ORDER TO RECEIVE THE VALUABLE INFORMATION NECESSARY TO MAKE A CAREFUL COMPARISON IF YOU ARE CONTEMPLATING REPLACEMENT, THE AGENT OR BROKER IS REQUIRED TO ASK YOU THE FOLLOWING QUESTIONS AND EXPLAIN ANY ITEMS THAT YOU DO NOT UNDERSTAND.

AS PART OF YOUR PURCHASE OF A NEW LIFE INSURANCE POLICY OR A NEW ANNUITY CONTRACT, HAS EXISTING COVERAGE BEEN, OR IS IT LIKELY TO BE:

(1) LAPSED, SURRENDERED, PARTIALLY SURRENDERED, FORFEITED, ASSIGNED TO THE INSURER REPLACING THE LIFE INSURANCE POLICY OR ANNUITY CONTRACT , OR OTHERWISE TERMINATED? ☐ YES ☐ NO

(2) CHANGED OR MODIFIED INTO PAID-UP INSURANCE; CONTINUED AS EXTENDED TERM INSURANCE OR UNDER ANOTHER FORM OF NONFORFEITURE BENEFIT; OR OTHERWISE REDUCED IN VALUE BY THE USE OF NONFORFEITURE BENEFITS, DIVIDEND ACCUMULATIONS, DIVIDEND CASH VALUES OR OTHER CASH VALUES? ☐ YES ☐ NO

(3) CHANGED OR MODIFIED SO AS TO EFFECT A REDUCTION EITHER IN THE AMOUNT OF THE EXISTING LIFE INSURANCE OR ANNUITY BENEFIT OR IN THE PERIOD OF TIME THE EXISTING LIFE INSURANCE OR ANNUITY BENEFIT WILL CONTINUE IN FORCE? ☐ YES ☐ NO

(4) REISSUED WITH A REDUCTION IN AMOUNT SUCH THAT ANY CASH VALUES ARE RELEASED, INCLUDING ALL TRANSACTIONS WHEREIN AN AMOUNT OF DIVIDEND ACCUMULATIONS OR PAID-UP ADDITIONS IS TO BE RELEASED ON ONE OR MORE OF THE EXISTING POLICIES? ☐ YES ☐ NO

(5) ASSIGNED AS COLLATERAL FOR A LOAN OR MADE SUBJECT TO BORROWING OR WITHDRAWAL OF ANY PORTION OF THE LOAN VALUE, INCLUDING ALL TRANSACTIONS WHEREIN ANY AMOUNT OF DIVIDEND ACCUMULATIONS OR PAID-UP ADDITIONS IS TO BE BORROWED OR WITHDRAWN ON ONE OR MORE EXISTING POLICIES? ☐ YES ☐ NO

(6) CONTINUED WITH A STOPPAGE OF PREMIUM PAYMENTS OR REDUCTION IN THE AMOUNT OF PREMIUM PAID? ☐ YES ☐ NO

IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, A REPLACEMENT AS DEFINED BY NEW YORK INSURANCE REGULATION 60 HAS OCCURRED OR IS LIKELY TO OCCUR AND YOUR AGENT OR BROKER IS REQUIRED TO PROVIDE YOU WITH THE **IMPORTANT** NOTICE REGARDING REPLACEMENT OR CHANGE OF LIFE INSURANCE POLICIES OR ANNUITY CONTRACTS. YOU WILL ALSO RECEIVE A COMPLETED DISCLOSURE STATEMENT NO LATER THAN THE TIME YOUR NEW POLICY OR NEW CONTRACT IS DELIVERED.

Date: _____ Signature of Applicant _____

Date: _____ Signature of Applicant _____

To the best of my knowledge, a replacement is involved in this transaction: ☐ YES ☐ NO

Date: _____ Signature of Agent or Broker: _____

Copies provided to Insurance Company, Agent, and Applicant

Prudential

Corporate Offices
Newark, New Jersey 07102

☐ **The Prudential Insurance Company of America, or**
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DEPARTMENT OF FINANCIAL SERVICES OF THE STATE OF NEW YORK - DEFINITION OF REPLACEMENT

IN ORDER TO DETERMINE WHETHER YOU ARE REPLACING OR OTHERWISE CHANGING THE STATUS OF EXISTING LIFE INSURANCE POLICIES OR ANNUITY CONTRACTS, AND IN ORDER TO RECEIVE THE VALUABLE INFORMATION NECESSARY TO MAKE A CAREFUL COMPARISON IF YOU ARE CONTEMPLATING REPLACEMENT, THE AGENT OR BROKER IS REQUIRED TO ASK YOU THE FOLLOWING QUESTIONS AND EXPLAIN ANY ITEMS THAT YOU DO NOT UNDERSTAND.

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(1) LAPSED, SURRENDERED, PARTIALLY SURRENDERED, FORFEITED, ASSIGNED TO THE INSURER REPLACING THE LIFE INSURANCE POLICY OR ANNUITY CONTRACT , OR OTHERWISE TERMINATED? ☐ YES ☐ NO

(2) CHANGED OR MODIFIED INTO PAID-UP INSURANCE; CONTINUED AS EXTENDED TERM INSURANCE OR UNDER ANOTHER FORM OF NONFORFEITURE BENEFIT; OR OTHERWISE REDUCED IN VALUE BY THE USE OF NONFORFEITURE BENEFITS, DIVIDEND ACCUMULATIONS, DIVIDEND CASH VALUES OR OTHER CASH VALUES? ☐ YES ☐ NO

(3) CHANGED OR MODIFIED SO AS TO EFFECT A REDUCTION EITHER IN THE AMOUNT OF THE EXISTING LIFE INSURANCE OR ANNUITY BENEFIT OR IN THE PERIOD OF TIME THE EXISTING LIFE INSURANCE OR ANNUITY BENEFIT WILL CONTINUE IN FORCE? ☐ YES ☐ NO

(4) REISSUED WITH A REDUCTION IN AMOUNT SUCH THAT ANY CASH VALUES ARE RELEASED, INCLUDING ALL TRANSACTIONS WHEREIN AN AMOUNT OF DIVIDEND ACCUMULATIONS OR PAID-UP ADDITIONS IS TO BE RELEASED ON ONE OR MORE OF THE EXISTING POLICIES? ☐ YES ☐ NO

(5) ASSIGNED AS COLLATERAL FOR A LOAN OR MADE SUBJECT TO BORROWING OR WITHDRAWAL OF ANY PORTION OF THE LOAN VALUE, INCLUDING ALL TRANSACTIONS WHEREIN ANY AMOUNT OF DIVIDEND ACCUMULATIONS OR PAID-UP ADDITIONS IS TO BE BORROWED OR WITHDRAWN ON ONE OR MORE EXISTING POLICIES? ☐ YES ☐ NO

(6) CONTINUED WITH A STOPPAGE OF PREMIUM PAYMENTS OR REDUCTION IN THE AMOUNT OF PREMIUM PAID? ☐ YES ☐ NO

IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, A REPLACEMENT AS DEFINED BY NEW YORK INSURANCE REGULATION 60 HAS OCCURRED OR IS LIKELY TO OCCUR AND YOUR AGENT OR BROKER IS REQUIRED TO PROVIDE YOU WITH THE **IMPORTANT** NOTICE REGARDING REPLACEMENT OR CHANGE OF LIFE INSURANCE POLICIES OR ANNUITY CONTRACTS. YOU WILL ALSO RECEIVE A COMPLETED DISCLOSURE STATEMENT NO LATER THAN THE TIME YOUR NEW POLICY OR NEW CONTRACT IS DELIVERED.

Date: _____ Signature of Applicant _____

Date: _____ Signature of Applicant _____

To the best of my knowledge, a replacement is involved in this transaction: ☐ YES ☐ NO

Date: _____ Signature of Agent or Broker: _____

Copies provided to Insurance Company, Agent, and Applicant

NY Regulation 200 Information Request

Prudential

The Prudential Insurance Company of America
Pruco Life Insurance Company of New Jersey
Both are Prudential companies.

POLICY NUMBER: ______________________________

PROPOSED INSURED: ______________________________

NY Regulation 200 requires the Company to request the following information prior to a policy's issuance to ensure that all benefits or other monies are distributed to the appropriate persons upon the death of the insured. This information is requested of every owner, additional insured and beneficiary listed on your application for life insurance.

Provide in the spaces below the following information, as applicable, for each proposed owner other than the primary proposed insured and beneficiary listed on your application for insurance: first, middle and last name; complete address with street, city, state and ZIP; date of birth; Social Security Number (SSN) or Tax Identification Number (TIN); home telephone number; cell telephone number; e-mail address. Also, if the application includes a Child Rider, the information is also requested for each proposed child.

Use additional copies of this form for additional beneficiaries, children proposed for coverage or proposed owners.

NOTE: THIS IS NOT A FORM TO REQUEST ANY CHANGES TO THE INFORMATION PROVIDED AS PART OF YOUR APPLICATION.

A. APPLICABLE TO ALL ENTITIES, INDIVIDUALS AND TRUSTS NAMED AS BENEFICIARIES ON THE APPLICATION

Beneficiary(ies):

Name: First: ______________ Middle: ______________ Last: ______________
Address: Street: ______________________________
City: ______________ State: ______________ ZIP: ______________
Home Phone: ______________ Cell Phone: ______________
e-mail address: ______________________________
Date of Birth: ______________ SSN/TIN: ______________ Relationship: ______________

Name: First: ______________ Middle: ______________ Last: ______________
Address: Street: ______________________________
City: ______________ State: ______________ ZIP: ______________
Home Phone: ______________ Cell Phone: ______________
e-mail address: ______________________________
Date of Birth: ______________ SSN/TIN: ______________ Relationship: ______________

Name: First: ______________ Middle: ______________ Last: ______________
Address: Street: ______________________________
City: ______________ State: ______________ ZIP: ______________
Home Phone: ______________ Cell Phone: ______________
e-mail address: ______________________________
Date of Birth: ______________ SSN/TIN: ______________ Relationship: ______________

Name: First: ______________ Middle: ______________ Last: ______________
Address: Street: ______________________________
City: ______________ State: ______________ ZIP: ______________
Home Phone: ______________ Cell Phone: ______________
e-mail address: ______________________________
Date of Birth: ______________ SSN/TIN: ______________ Relationship: ______________

B. ONLY PROVIDE THE FOLLOWING DETAILS FOR ANY CHILD(REN) UNDER A CHILD RIDER REQUESTED ON THE APPLICATION

Proposed Child(ren):

Name: First: _____ Middle: _____ Last: _____

Address: Street: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Cell Phone: _____

e-mail address: _____

Date of Birth: _____ SSN: _____

Name: First: _____ Middle: _____ Last: _____

Address: Street: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Cell Phone: _____

e-mail address: _____

Date of Birth: _____ SSN: _____

Name: First: _____ Middle: _____ Last: _____

Address: Street: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Cell Phone: _____

e-mail address: _____

Date of Birth: _____ SSN: _____

C. COMPLETE ONLY IF THE OWNER IS TO BE OTHER THAN THE PRIMARY PROPOSED INSURED

Proposed Owner(s):

Name: First: _____ Middle: _____ Last: _____

Address: Street: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Cell Phone: _____

e-mail address: _____

Date of Birth: _____ SSN/TIN: _____

Name: First: _____ Middle: _____ Last: _____

Address: Street: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Cell Phone: _____

e-mail address: _____

Date of Birth: _____ SSN/TIN: _____

Name: First: _____ Middle: _____ Last: _____

Address: Street: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Cell Phone: _____

e-mail address: _____

Date of Birth: _____ SSN/TIN: _____

Prudential

Preliminary Statement of Policy Cost

The Prudential Insurance Company of America
Pruco Life Insurance Company of New Jersey
both are Prudential companies
Corporate Offices, Newark, New Jersey 07102 – 973-802-6000

Policy No. _____

Proposed Insured _____ **Issue Age** _____ **Sex** _____

Proposed Insured _____ **Issue Age** _____ **Sex** _____

The purpose of this Preliminary Statement of Policy Cost and the Buyer's Guide is to provide information which will help you decide how much life insurance you should buy, improve your ability to select the most appropriate plan of insurance for your needs, improve your understanding of the most basic features of the policy which has been purchased or which is under consideration, and improve your ability to evaluate the relative costs of similar plans of insurance.

BASIC POLICY

Description	Initial Amount of Life Insurance	Initial Annual Premium

	10th Year*	20th Year*
Life Insurance Net Payment Cost Comparison Index at 5%		
Life Insurance Surrender Cost Comparison Index at 5%		
Guaranteed Cash Surrender Values		

**Values will only be shown for durations during the premium paying period.*

An explanation of the intended use of these indexes is provided in the Life Insurance Buyer's Guide. The description of the coverage is general. A complete statement of coverage is found only in the policy.

If applicable, we will charge interest daily on any loan taken at a fixed interest rate of 8.00% for the Prudential Guaranteed Life and Return of Premium Term products. For PruLife® Universal Protector, the standard loan interest rate is 2.00%. After 10 years, the policy may be eligible for a preferred loan with an interest rate of only 1.25%. For PruLife® SUL Protector, the standard loan interest rate is 3.00%. After 10 years, the policy may be eligible for a preferred loan with an interest rate of only 2.25%. Interest is payable in arrears.

Please Note: When the policy is issued, you will be given a complete Policy Summary, including cost data, which will be based on the benefits and premiums of the policy as issued; and that, following the receipt of the policy and policy summary, there will be a period of not less than ten days within which the applicant may return the policy for an unconditional refund of the premiums paid.

If it is impractical to provide any of the above items prior to application, they may be estimated in good faith or furnished as soon thereafter as practical prior to delivery of the policy. However, no application shall be prevented or delayed because of any missing information on this form.

Signature of Agent: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

Signature of Applicant: **X** _____

Prudential

Preliminary Statement of Policy Cost

The Prudential Insurance Company of America
Pruco Life Insurance Company of New Jersey
both are Prudential companies
Corporate Offices, Newark, New Jersey 07102 – 973-802-6000

Policy No. _____

Proposed Insured _____ **Issue Age** _____ **Sex** _____

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